

DISCHARGE PLAN FOR CHILD WITH COMPLEX MEDICAL NEEDS

Child's Name	Link Number	Date of Birth
Diagnosis		
Foster Parent Name		Telephone
Address		
DCF Social Worker		Telephone
DCF Area Office		
Primary Health Care Provider		Telephone

☐ **MEDICAL NEEDS AND EQUIPMENT**

- | | | |
|---|--|---|
| <input type="checkbox"/> Continuous O ₂ | <input type="checkbox"/> Apnea Monitor | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Intermittent O ₂ | <input type="checkbox"/> Sidelyer | <input type="checkbox"/> Stander |
| <input type="checkbox"/> Tracheostomy Care | <input type="checkbox"/> Suctioning | <input type="checkbox"/> Nasogastric Tube |
| <input type="checkbox"/> Ventilator Length of Time: | <input type="checkbox"/> Nebulizer | <input type="checkbox"/> Gastrostomy Tube |
| <input type="checkbox"/> Continuous Positive Airway Pressure Length of Time: | | <input type="checkbox"/> Other: |

☐ **ALLERGIES (List):**

☐ **CURRENT MEDICATIONS:**

Prescription/Non-Prescription:	Dosage	Frequency

Immunizations: (During Hospitalization)

☐ **SPECIAL DIET:**

☐ **EDUCATIONAL NEEDS:****At-home services:**

Service	Frequency	Location

Out-of-home services:

Service	Frequency	Who Provides Transportation	Location

☐ **THERAPY NEEDS:**

	Frequency	Location
<input type="checkbox"/> PT		
<input type="checkbox"/> OT		
<input type="checkbox"/> Speech		
<input type="checkbox"/> Other:		

☐ **DEVELOPMENTAL DELAY:**

☐ Yes ☐ No

If yes, explain:

☐ **PHYSICAL ENVIRONMENT:****Handicapped Access:**

☐ Bathroom ☐ Hallways ☐ Outside ramp ☐ Vehicle/wheelchair accessible ☐ Generator
☐ Other: (specify)

☐ **HOME CARE SERVICES:**

Agency:

Telephone:

Services Ordered:

☐ **FOLLOW-UP APPOINTMENTS:**

Health Care Provide Name	Specialty	Telephone	Appointment Date

☐ **ADDITIONAL COMMENTS:**☐ **SIGNATURES:**

Person Completing this Form:	Title:	Date:
DCF Social Worker:		Date:
Reviewed by RRG Nurse:		Date:
Approved by Area Office Behavioral Health PD:		Date:

